MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Dr. Alan Berg 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-4376-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Co. c/o ACE USA/ESIS 8310 North 360, Ste. 175 Austin, TX 78731 BOX 15	Date of Injury: Employer's Name: Pat Salmon & Sons Inc. Insurance Carrier's No.: 0709002A364000401I

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/03/03	03/10/03	99204, 99080-73, 95851, 97110, 97139-PH, 99070 – Hydrocortizone, 99070-Lumbar Roll, 97070-Polar Pac, 99071-Lumbar book, 97010, 97032. 97530, 97035, 97799-JA, A9150, 99213, 97039, and 64999	$5,415.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 11/26/03 states in part, "We have attempted to submit in our billing to the carrier via certified mail as a second request. According to USPC Tracing Confirmation, the carrier received our request on June 6, 2003. To date the carrier has not responded to our billing as required by TWCC".

PART IV: RESPONDENT'S POSITION SUMMARY

Response not submitted by the Respondent

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Rule 133.307(e)(2)(B) the requestor has not submitted convincing evidence (i.e. a signed copy of the return receipt request) of request for reconsideration for the dates of service and CPT/HCPCS codes in dispute; therefore, reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	02/11/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____